



From the office of the Fiscal Agent

Kansas Medical Assistance Programs

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Elidel/Protopic - Initial Prior Authorization Request Form

Consumer Name: _____

Consumer Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Drug Name: _____ NDC Requested: _____

Prescribing Physicians Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

1. Please indicate the diagnosis for which Elidel/Protopic is being prescribed (no dx codes):

2. Document inadequate response or contraindications to first line agents as recommended in manufacturer labeling and FDA Public Health Advisory.

Prescribing Physician's Signature: _____ Date: ____/____/____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.

This form will be returned unprocessed if it is not completed in its entirety.

**If a case has been started and the information requested is not received within
15 working days, the case will be denied.**